We also agree that the clinical significance of the initial intracellular fluid to extracellular fluid (ICF/ECF) ratio is great and is the major (new) point of the paper.

Dr Tzamaloukas's suggestion that simply "the greater the glucose concentration, the larger the decrease in sodium concentration" is in error. It is incorrect precisely because of the very importance of volume status in determining ΔPNa/ΔPG. For example, an edematous patient with a 10% gain in body weight due to fluid and a plasma glucose concentration of 800 mg per dl will have a depression of serum sodium concentration of approximately 9 mEq per liter. On the other hand, a volume-depleted patient with a 10% loss and a (lesser) glucose concentration of 700 mg per dl will nonetheless have a *larger* reduction in sodium concentration, approximately 11 mEq per liter.

The importance of the patient's volume status in assessing hyperglycemic hyponatremia is paramount.

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Fatigue Fracture, Not Pseudofracture

TO THE EDITOR: The case report "Pseudofractures in Patients With Low-Turnover Osteoporosis" in the August 1985 issue[1] is a well worked up presentation of fatigue fractures in osteoporotic bone, rather than pseudofracture. The radiographic appearance as well as the clinical workup are quite characteristic.

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REFERENCE

1. Orwoll ES, McClung MR: Pseudofractures in patients with low-turnover osteoporosis. West J Med 1985 Aug; 143:239-242

The Class of '85: OB Malpractice Fee Phobia Among Medical Students

TO THE EDITOR: A nationwide decline in ob/gyn specialists' involvement in obstetrics has been noted in a recent news service item ("Obstetrical Services Decline." *The San Bernardino Sun*, February 12, 1985, p 17—*New York Times* News Service). Having interviewed family medicine residency applicants over the past nine years, it has become apparent that the desire to do or not do obstetrics is a "watershed" issue for medical students who desire further training in family medicine.[1-3] The malpractice insurance premiums have always been a factor in the considerations of these students. In fact, it appeared that many students based much of their career choice on what they anticipated as the financial feasibility of providing this service (with malpractice insurance premiums being a major financial burden).

To determine the potential impact of perceived financial liability, fourth-year medical student residency applicants were asked a series of questions about anticipated practice style regarding obstetrical services and cost of malpractice insurance premiums.

The first question was whether or not they were likely to do obstetrics as a part of their family medicine practice. Second, students were asked what they anticipated to be the dollar cost of yearly malpractice premiums to family physicians for simple nonoperative obstetrics. This was to be a "first year in practice" cost.

As a second part of the study, current malpractice carriers in California provided quotes regarding their premiums for board-certified family physicians providing obstetrical services. This information is tabulated yearly by the California Medical Association for its membership. This document provided information regarding malpractice insurance premium rates for 1984 and 1985 (Table 1).

In all, 63 applicants completed the study; there were no exclusions. This group represented 30% of the applicants who completed the application process. Approximately half felt that they were committed to a family practice that contained obstetrical services, whereas an equal number felt unprepared to make this commitment (Table 2). Approximately a third of the students felt that they definitely would not do obstetrics. Table 2 compares the estimates of first-year malpractice costs in southern California by ob-committed residency applicants versus ob-noncommitted residency applicants. The averages of these estimates are discordant by more than $10,000 per year.

When asked the source of these quotes, the students stated that they had been told by their professors or senior residents in medical school that these were the costs that they could expect. Regardless of the source, it appears that these estimates are not accurate. Medical schools should distribute accurate information regarding this important aspect of medical practice. In this way, medical students can make an informed decision regarding their options for future medical training. Can there be educational malpractice insurance on behalf of those who are incorrectly counseled?

Since students already face the dilemma of declaring their specialty choice before any "real world experience," it seems that financial information of this type is important to students

TABLE 1.—*The First Year Cost of Malpractice Insurance Upon Entering Family Practice With Uncomplicated Obstetrics*

	1984	1985
Company 1	$2,262	$2,640
Company 2	$2,668	$3,120
Company 3	$2,536	$3,032

These figures represent malpractice premiums for physicians "new in practice" who are receiving the **50% discount** on first year rate. Three malpractice carriers were chosen randomly from information provided by the California Medical Association.

TABLE 2.—*Students Citing Malpractice Insurance Costs as a Determinant in Their Decision Not to Do Obstetrics*

	Unlikely to Do	Likely to Do
Number of medical students surveyed	N = 31	N = 32
Average annual insurance premium predicted cost (with OB)	$27,500	$14,000
Range of predicted costs per annual malpractice insurance premiums	$16K-60K	$4K-25K